Founded 1872

BULLETIN

THE MAHONING COUNTY MEDICAL SOCIETY
Volume LIX Number 9 December 1989

COUNCIL

Officers

Karl F. Wieneke, M.D.
President
James A. Lambert, M.D.
Vice President
Kimbroe J. Carter, M.D.
Secretary
Danny Chung, M.D.
Treasurer
Hai-Shiuh Wang, M.D.
Immediate Past President

Board of Censors

Karl F. Wieneke, M.D.
James A. Lambert, M.D.
Hai-Shiuh Wang, M.D.

AMA Alternate Delegate

J.J. Anderson, M.D.

OSMA Delegates

J.James Anderson, M.D.
James A. Lambert, M.D.
Lloyd E. Slusher, M.D.
Hai-Shiuh Wang, M.D.
Karl F. Wieneke, M.D.

OSMA Alternate Delegates

A. Gary Bitonte, M.D.
Thomas N. Detesco, M.D.
Brian S. Gordon, M.D.
Prabhudas R. Lakhani, M.D.
Richard A. Memo, M.D.

Members At Large

Chester A. Amedia, M.D.
Glenn J. Baumblatt, M.D.
Jane F. Butterworth, M.D.
Salim El-Hayek, M.D.
James F. Ervin, M.D.
John G. Guju, M.D.
Murali Guthikonda, M.D.
Althanoios D. Kasamias, M.D.
Milton J. Lenhart, M.D.
Catherine E. Molloy, D.O.

Public Relations Director

Jane F. Butterworth, M.D.

Editor

Brian S. Gordon, M.D.

BULLETIN

MAHONING COUNTY MEDICAL SOCIETY
Volume LIX December 1989 Number 9

Table of Contents

1989 MAHONING COUNTY MEDICAL SOCIETY MEETINGS

Tuesday - Jan. 21
Tuesday - March 21
Tuesday - May 23
Tuesday - September 19
Tuesday - November 21
Tuesday - December 19

The Bulletin is published nine times a year monthly with the exception of May, July & August, by the Mahoning County Medical Society, 5104 Market St., Youngstown, OH 44512. Ph. 216/788-4700. Eleanor Pershing, Executive Director

EDITOR
Brian S. Gordon, M.D.

MANAGING EDITOR
Eleanor Pershing

EDITORIAL STAFF
Emil S. Dickstein, M.D.
Robert R. Fisher, M.D.
John R. LaManna Jr., M.D.
John C. Melnick, M.D.

President's Page

Karl F. Wieneke, M.D.

As the year 1989 comes to a close, so, too, does my year as President of the Mahoning County Medical Society. In this, my last message to the membership, I want to take the opportunity to express my warmest thanks to our Executive Director, Eleanor Pershing, and to our Secretary, Patricia Wadjun, who have been so helpful to me and who are absolutely essential to the smooth functioning of this organization. I, also, want to sincerely thank the members of Council and all committee members who have made my duties lighter this year. Their interest and enthusiasm, in addition to their ideas and constructive criticism, really enabled me to carry out my responsibilities as President.

With the end of 1989, we closeout the decade of the eighties, a decade that has seen great changes in the practice of medicine. Many of these changes have not been for the better. These changes have been brought about largely by economic considerations and expediency, often at the cost of lessening the quality of medical care for our patients. Even as the troublesome decade of the eighties comes to a close, perhaps we can look forward to the coming of the nineties with hopeful anticipation that any future changes in medicine will ultimately bring about the continuing improvement in health care for all in an environment which is professionally satisfying and rewarding. But regardless of what happens, and in spite of it all, medicine remains a rewarding and noble profession of which we all can be proud. From time to time, we, as physicians, need to remind ourselves of the emotional fulfillment and feelings of personal satisfaction that only the practice of medicine can give. And, as each of us continues to pursue his or her own personal and professional goals, let us occasionally turn for encourgement to the Greatest Physician of all, as we seek His assistance and guidance, in the following prayer:

I Pray, Dear God

Give skill to my hand, clear vision to my mind, kindness and sympathy to my heart.

Give me singleness of purpose, strength to lift at lease part of the burden of my suffering fellowmen and a true realization of the privilege that is mine.

From the Desk of the Editor

Brian S. Gordon, M.D.

A Divergence of Goals

For the most of this century the goals of hospitals and medical staffs were the same. All were concerned with the care of the patient. In most cases the medical staff even ran the philosophical and financial decision making of the hospital boards. Those were the days of "wine and roses".

Then came the 1970's and the ralization that technology was expensive. Moreover, the money to pay for the technology as well as taking care of the patient, even without high technology, was costing more that the insurance blank checks could handle. The 1980's brought this to a head with the addition of lowered payments, increased utilization of facilities, and additional burdens on both the medical staffs and hospitals to just survive.

During this time we witnessed a shifting of goals. No longer were hospitals solely responsible for patients, but also needed to create "cost centers" in which to maximize profiles in order to weather financial storms. Boards could no longer afford to have physicians make major decisions, but rather lawyers, business men, and professional managers were called upon to judge whether services performed for the patient could be justified in terms of profits and image. The medical staffs, on the other hand, still concerned themselves with the now apparently outmoded concept of patient care and advocacy.

The direction of the 1990's would therefore be expected to completely isolate the medical staff from the hospital. Therefore, bridging goals with the cooperation of both entities must be achieved.

Here's the plan! First, establish communications for common goals. Tear down the walls of distrust and miscommunication. Second, build binding bonds through contracts of individual groups of physicians and the hospital as well as strengthened bylaws which more realistically reflect the political, emotional, and social pressures which face both entities. Third, increase communications and goals on local, state, and national levels in order to ward off common enemies such as unfair rules and regulations of some governmental agencies. Finally, provide common goals for the quality care of the patients which we serve.

It's a "desperate struggle under incredible odds" which can only be carried out if goals once more are shared instead of becoming increasingly divergent.

Medical Decision Making

Leonard P. Caccamo M.D. FACP

An Introduction To Decision Tools
The Stick Diagram and The 2 X 2 Table

Leonard P. Caccamo M.D.
Kimbroe Carter M.D.

The structured reasoning of decision analysis falls into 2 major categories, best described using decision tree and algorithmic models. Algorithms provide a structured step by step pathway of instruction, based upon well defined "RULES" providing a consensus of "WHAT" to do when a certain clinical result is obtained, although the "WHY" and "HOW" are not evident. On the other hand decision trees are pre algorithmic since they assist us in obtaining a consensus by utilizing Bayes' Theorem to adjust the probability of a prior hypothesis as additional information is gathered.

THE IMPORTANCE OF PROBABILITY

In our imperfect and uncertain world probability assessment assumes a fundamental role. Probability is any number between 0 and 1 that reflects an estimate or opinion of the likelihood of an event. The certainty of an event is signified by the number 1, while the probability that an event will not occur is signified by the number 0. The degree of uncertainty is expressed as a number between these two extremes, 0 and 1, the larger the number the higher the degree of certainty of the event occuring. Odds are another way expressing certainty and the odds ratio favoring an event is the ratio of the probability of an event P divided by the probability of the event not occurring 1 - P.

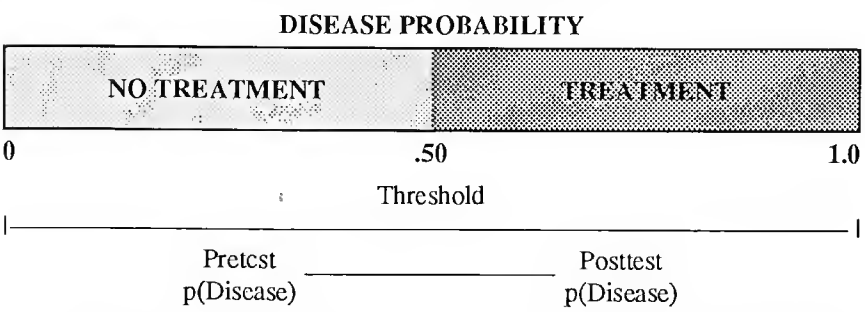
Therefore: Odds = P/(1-P)

For example:
IF Probability = 0.25 THEN Odds = 0.25/(1 - 0.25) or 0.25/0.75 or 1/3

At times probability has a very objective meaning and is a measurable quantity within a defined group of patients. At other times probability, may, for example, reflect the physician's personal estimate and thus take on a more subjective value. An example of such subjective probability is the doctor's intuitive predication of a patient's ability to survive a particular surgical procedure in the face of multiple chronic diseases. Here we see an example of a physician's instinctive disciplined thinking, a synthesis of intuition, reflection and past experience.

We have now introduced the idea of probability and the inescapable dilemma of uncertainty during patient management. The mechanics of this process will now be briefly presented. In a sense the process of making a decision is comparable to crossing a threshold. One must realize that the treatment threshold is that probability point above which medical action will be taken and below which no

action will be taken. Let us take a look at the graph below:



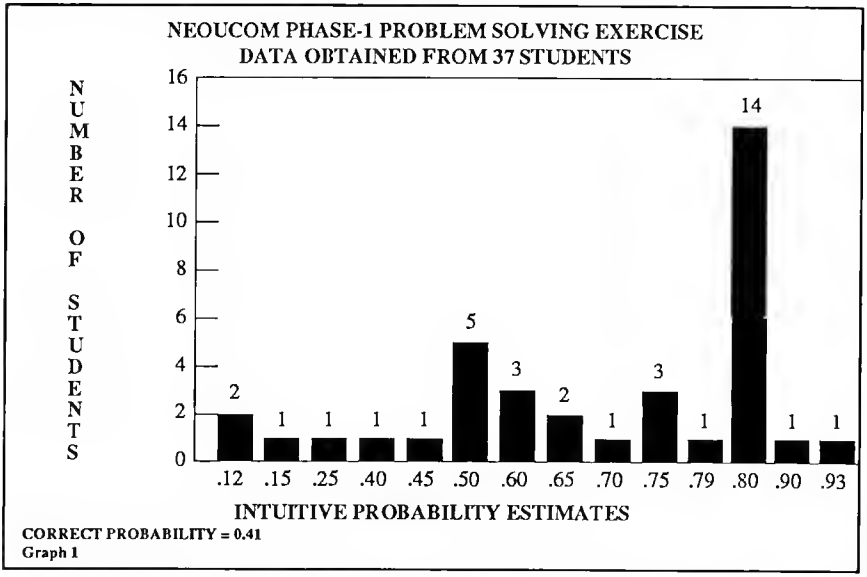
Along the lower portion of the graph is a numerical scale reflecting the range of probability that the disease is present. The threshold is identified by the carrot and indicates the point (^) of uncertainty (probability) above which treatment will be given.

The enigma which the decision-maker faces is the prior probability or prevalence of the disease as it specifically pertains to the patient in question. If there is sufficient uncertainty and the assessment of the disease state is below the threshold point then no treatment will be given. The problem then may be OBSERVED and/or diagnostic TESTS entertained! What is important in deciding where the threshold should be positioned, is the competing values of potential treatment costs in patients who do not have the disease (false positive disease state) and the resulting potential treatment risks, another expression of the cost of treatment. Indeed there is considerable deliberation at times by the practioner in deciding between these two competing forces.

[Let us investigate a hypothetical clinical problem.]

A 65 year old teacher visits his family doctor for a routine annual checkup. He has no complaints, and the physician finds no significant abnormalties on physical examination. There is however, a family history for cancer of the colon in the patient's father. The medical literature suggests that the incidence of this particular type of familial cancer is 15% in a son or daughter. A routine hemoccult test is made on the stool obtained during the rectal examination and found to be positive. In the office this test is expected to correctly identify patients WITH and WITHOUT colon cancer 80% of the time. This last statement indicates that the SENSITIVITY of the test is 80% when positive and indicates that it will identify 80% of those WITH the disease. This statement also implies that the SPECIFICITY of the test is also 80% indicating that when the test is negative the test will identify 80% of those WITHOUT the disease!

We asked you to estimate the probability that this teacher had colon cancer. Most individuals respond to this type of question with an answer close to an 80% probability, paying for too little attention to the fact that the PRIOR PROBABILITY of cancer is only 15% in a similar type question 19 out of 37 NEOUCOM medical students estimated probability between 75 - 95%. Please note Graph 1.



Graph 1

The true answer in this case is that the predictive value of a positive hemoccult test equals 41%. This is the probability that the patient has cancer based upon the positive test for occult blood. This example emphasizes the physician's problem of ascertaining the likelihood of a patient's having a particular disease, given a positive laboratory tes result. One should NEVER interpret a positive test as being equivalent to the probability that the patient has the disease!

Reverend Thomas Bayes, an 18th century Presbyteian minister, described a mathematical technique that may be used to help us solve such problems as that posed in last months hypothetical case. We also left you to meditate upon a proposition to which we will now add a second statement:

PRIOR PROBABILITY	BAYES' THEOREM	POSTERIOR PROBABILITY
PREVALENCE OF DISEASE STATE	PROBABILITY OF TEST RESULT	POSTERIOR PROBABILITY OF DISEASE STATE GIVEN TEST RESULT

We will now create a stick diagram to illustrate the solution and which takes into account the PREVALENCE of the disease in patients with such a family history for cancer as will as the SENSITIVITY and SPECIFICITY of the hemoccult test being utilized. Adjusting such initial probability estimates for additional information provided by testing falls into the inferential techniques handled by Bayes' Theorem. We shall now refer to (Figure 2) where we begin by assuming a population of 100 patients identical to the case in question.

SOLUTION IN A STICK DIAGRAM
ASSUME 100 PEOPLE WITH SIMILAR FAMILY HISTORY

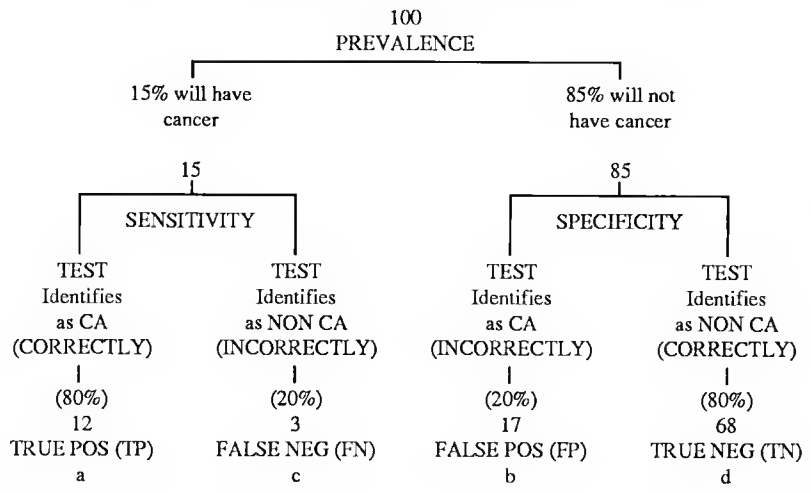


Figure 2

a = 12 "true positive hits" b = 17 "false positive misses"
a + b = "29" total number of positive tests

PROBABILITY OF CANCER GIVEN A POSITIVE TEST = True Positives/ All positives = a/(a + b) = 12/(12 + 17) = 0.41 or 41%

We may now summarize by utilizing a 2 X 2 box and the calculations derived from Stick Diagram in Figure 2 (next page)

2 X 2 TABLE
DERIVED FROM STICK DIAGRAM

	CANCER POPULATION	NO CANCER POPULATION	
TEST T+ Says CANCER	.80 X 15 = 12 a	.20 X 85 = 17 b	12/(12+17) = .41 a/(a +b)
TEST T- Says NO CANCER	.20 X 15 = 3 c	.80 X 85 = 68 d	
	(A + C)	(B + D)	100 PATIENTS
	15	85	

POSTERIOR POSITIVE PREDICTIVE VALUE = 0.41

Figure 3

TABLE 1
DERIVED FROM STICK DIAGRAM

(a) = TRUE POSITIVE (T+)
Patient has jointly a positive test and is correctly identified as having CANCER.

(b) = FALSE POSITIVE (T+)
Patient has jointly NO CANCER and a positive test which identifies him falsely as having CANCER which may lead to further tests and treatment that may be inappropriate and potentially harmful.

(c) = FALSE NEGATIVE (T-)
Patient has jointly CANCER and a negative test which falsely reassures and may lead to a missed diagnosis.

(d) = TRUE NEGATIVE (T-)
Patient has a negative test and is correctly identified as having NO CANCER!

Figure 4

PLEASE REVIEW THESE DIAGRAMS SINCE WE SHALL EXPAND UPON THESE BASIC PRINCIPLES AND THIS HYPOTHETICAL PROBLEM IN OUR FUTURE ARTICLES.

News from NEOUCOM

Charles G. Mickens

Medical Career Information for Minority Youth

Throughout the year, the Northeastern Ohio Universities College of Medicine (NEOUCOM) hosts several career orientation and motivational projects for youth. The Office of Minority Affairs coordinates the projects as part of its outreach efforts in the communities served by the College.

The projects are primarily designed to encourage youth from underrepresented groups in medicine and from rural areas to consider careers in medicine and other health care professions. Underrepresented groups in medicine include Black Americans, American Indians, Mexican Americns and Puerto Ricans. Rural communities are generally considered to be areas with a population of less than 2,500, which are not contiguous to larger metropolitan areas.

These groups are targeted because of the small number of health care professionals who come from these backgrounds. Recent statistics report that black individuals account for 2.6% of the physician manpower in the United states. This same group comprises 2.9% of dentists, 2.3 % of pharmacists and 1.6% of the country's veterinarians. Even with the addition of professionals from other minority groups, this figure seldom exceeds 3 % for any of the health care professions. These figures are small compared to the U.S. population which is about 12% black.

Youth from Mahoning, Trumbull and Columbiana couties annually participate in the Minority and Rural Students program (Project MARS) at NEOUCOM. Project MARS is a ten-week lecture series designed to introduce high school freshman and sophomores, and their parents, to medicine. The lecture series is hosted each Spring at NEOUCOM's basic medicine sciences campus in Rootstown. There, on Saturday mornings members of the college's faculty meet with participants to discuss basic science preparation for medicine, health care research and the various areas of specialization for physicians.

In addition, the students and parents learn about the six-year B.S./M.D. program at NEOUCOM and traditional, four-year medical schools.

The Project MARS program has been in existence since NEOUCOM's inception and has hosted more than 800 high school students. More than 60 participants applied, were admitted and enrolled in NEOUCOM. About 25% of that group were students from underrepresented groups in medicine and about 40% were from small towns in northeastern Ohio.

In the years 1980-1985, NEOUCOM conducted "Project Nine-By-Nine" with the cooperation of two of its consortium hospitals, Western Reserve Care System and Saint Elizabeth Hospital Medical Center, and the Mahoning Shenango Area Health Education Network. This program project provided a career exploration

activity for eighth and ninth grade students enrolled in the Youngstown City School System.

Participants spent one afternoon per week for six weeks visiting a health care facility. The other sessions included a student/parent orientation session, a visit to NEOUCOM's basic medical sciences campus in Rootstown and a visit to the Cleveland Health Education Museum. The program concluded with an awards program at which participants gave presentations and demonstrated to their parents what they learned during the project.

Throughout the program the participants met with practicing health care professionals. The professionals provided basic information about their areas of expertise. They also provided direction to the participants by emphasizing the academic preparation necessary to enter their field; discussing the necessary training; demonstrating some of the tasks associated with the specific profession; providing tours; discussing the advantages and disadvantages of their jobs and providing hands-on experiences for participants when practical.

The project Nine-By-Nine program has provided Youngstown area students with career information beyond that which is usually available to middle school students. The project has provided almost 350 students from the Youngstown area with information about courses in medicine, nursing, dentistry, respiratory therapy, physical therapy, occupational therapy, radiology, surgical assisting, clinical laboratory sciences, pharmacy, medical records and technical instrumentation.

If you wish to receive more information about these and other activities for high school and middle school students offered by NEOUCOM, please contact the Office of Minority Affairs at 216/747-2247, ext. 514.

Mr. Mickens is Director of Minority Affairs
at Northeastern Ohio Universities College of Medicine

Meetings

Council Meetings

The following applications were presented and approved during the Dec. 12, 1989 meeting of Council.

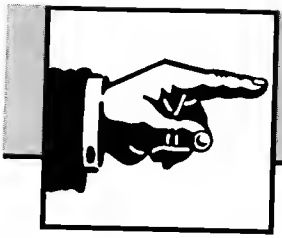
Active: James J. Berny, M.D. — Augustine P. Biscardi, D.O.
Suzan Lewis Selim, M.D. — Alta Ulhaq, M.D.

Second Year In Practice: Leonidas G. Vassilaros, M.D.

The following application was presented and approved during the January 9, 1990 meeting of Council.

Second Year In Practice: Denise Bobovnyik, M.D.

All applicants will become members of the Mahoning County Medical Society 15 days after their names have been published in the December issue of the Bulletin that is mailed to all members, unless an objection is received in writing by the executive director before that effective date.



Update

MEDICARE PIN AND MEDICARE UPIN

Nationwide - Medicare recently mailed a letter to all physicians providing them both their Medicare Provider (Physician) Identification Number (PIN) and the Medicare Unique Physician Identification Number (UPIN). Physicians who practice at more than one location were sent a separate letter at each address. For each location, the physician will have a different PIN number (the last digit will change), but only one UPIN will be assigned to each physician.

The PIN number is composed of two alpha characters and seven numerics (AB1234567). The UPIN number is a six-position alpha/numeric identifier (A12345). Physicians should continue to use their PIN to identify the ordering, referring and performing physician requirement. At this time, the UPIN number will not be used on the Midicare claim forms. However, it is important that physicians read the instructions in the letter and retain the letter on file, as the UPIN number will likely be used in the future.

As announced in the March 1989 Medicare Physician Newsletter, the identity (name, medical degree and PIN number) is required by radiologists, pathologists and attending physicians. The requirement does not apply to primary surgeons, anesthesiologists and assistant surgeons. If you have any questions regarding the PIN or UPIN call the OSMA Ombudsman staff at (800) 282-2712 extension 214, or (614) 486-2401.

INFECTIOUS WASTE ALERT

Some infectious waste haulers are misrepresenting to physicians the requirements for proper disposal of medical waste. In fact, at this time, there are no finalized standards for the disposal of infectious waste from physicians' offices.

The infectious waste legislation, Senate Bill 243, which passed last year, requires the Environmental Protection Agency to promulgate rules establishing disposal requirements for both large generators of infectious medical waste (more than 50 pounds of waste per month) and small generators (those producing less than 50 pounds per month). The EPA plans to submit their proposed rules to the Joint Committee on Agency Rule Review in the near future. These rules have not received final approval and are not yet effective. (OSMA will continue to keep physicians apprised of this situation).

NOW AVAILABLE

The 1990 Current Procedural Terminology (CPT) code book may be purchased from the AMA. The cost is $26.40 for AMA members and $33.00 for all others. Mail check and order request to: Book and Pamphlet Fulfillment, American Medical Association, P.O. Box 10946, Chicago, Illinois 60610-0946 (Visa and MasterCard orders only may be placed by calling (800) 621-8335)

MCMS New Members

Nicholas F. Agnesi, M.D.
548 Gypsy Lane
Youngstown, OH 44504
Phone: 743-2933
WRCS - General Surgery

Hi Moon Ahn, M.D.
S.E.H.M.C.
1044 Belmont Ave.
Youngstown, OH 44501
Phone: 746-7211
S.E.H.M.C. - Neonatology

Gregory X. Boehm, M.D.
510 Gypsy Lane #9
Youngstown, OH 44501
Phone: 743-4300
WRCS - General Psychiatry

Rafik Boutros, M.D.
4333 Belmont Ave.
Youngstown, OH 44504
Phone: 759-1269
S.E.H.M.C. - Anesthesiology

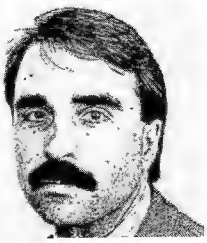
Thomas W. Crosby, M.D.
819 McKay Court #3
Youngstown, OH 44512
Phone: 743-2348
WRCS - Cardiology

David G. DeMarco, M.D.
7341 Eisenhower Dr.
Youngstown, OH 44512
Phone: 726-1138
WRCS - Internal Medicine

Robert E. Fisher, M.D.
345 Oak Hill Avenue
Youngstown, OH 44501
Phone: 740-4176
WRCS - Hematology-Oncology

William L. Houser, Jr., M.D.
850 McKay Court
Youngstown, OH 44512
Phone: 726-1664
WRCS - Pediatrics

Michael L. Ketcham, D.O.
1319 Florencedale Ave.
Youngstown, OH 44501
Phone: 744-9108
YOH - Radiology

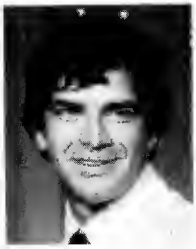


Chris A. Knight, M.D.
345 Oakhill Ave.
Youngstown, OH 44501
Phone: 740-4176
WRCS - Internal Medicine
Hematology-Oncology

Frederick G. Kurz, M.D.
6505 Market Street
Youngstown, OH 44512
Phone: 758-8900
WRCS - Anesthesiology

James N. Kvale, M.D.
1053 Belmont Ave.
Youngstown, OH 44501
Phone: 744-2750
S.E.H.M.C. - Family Practice

William A. Price, M.D.
860 Bdmn.-Canfield Rd. #201
Youngstown, OH 44512
Phone: 758-6401
S.E.H.M.C. - Psychiatry



Kevin G. Ragosta, D.O.
500 Gypsy Lane
Youngstown, OH 44501
Phone: 740-3943
WRCS - Tods Children-
Pediatrics Critical Care
Medicine

Bhargava Ravi, M.D.
550 Paramalee - Suite 310
Youngstown, OH 44510
Phone: 747-8611
S.E.H.M.C. - Internal Medicine

William G. Reeves, M.D.
345 Oak Hill Avenue
Youngstown, OH 44501
Phone: 740-4176
WRCS - Internal Medicine

Charles E. Smart, M.D.
253 Federal Plaza West
Youngstown, OH 44501
Phone: 743-4122
Pathology

James Smith, M.D.
12 Colonial Drive
Youngstown, OH 44505
Phone: 749-7733
WRCS - General Surgery

George Spirtos, M.D.
7355 Califomia Ave.
Youngstown, OH 44512
Phone: 726-0082
S.E.H.M.C. - General Surgery

Manuel M. Spirtos, M.D.
7355 Califomia Ave.
Youngstown, OH 44512
Phone: 726-0082
WRCS - Tods Childrens-
Pediatrics

Ralph G. Walton, M.D.
6505 Market Street
Youngstown, OH 44512
Phone: 726-5947
WRCS- General Psychiatry

Milo N. Warner, D.O.
1323 Florencedale Ave.
Youngstown, OH 44501
Phone: 746-2838
YOH - General Surgery

The Associate Dean's Column

W. Robert Kennedy, Ph.D.

Scientific Literacy in Our Society

If you were to take a sample of your friends, acquaintances, or paticnts over 18 years of age and ask them the following questions, what would be their correct response rate?

- Oxygen comes from plants
- The earth rotates around the sun once a year
- The center of the earth is very hot
- Humans and dinosaurs lived at the same time
- Continents are continually moving

What if you followed with questions such as these?

- Boiling radioactive milk will make it safe
- Satisfactorily explain the meaning/explanation of a "1 in 4 probability"
- Antibiotics do not kill viruses
- Eating animal fat may cause heart disease

These questions were part of a limited pool of standardizcd items given to random samples of adults (18 and older) in the U.S. and England. In response to the first group of questions, those dealing with "scientific terms and concepts", the percentage of responders classified as having a minimal level of understanding was U.S.=28.1% and England=28.5%.

The second questions focused upon the "impact of science and technology" yielded a minimal level of knowledge of U.S. = 49.9% correct, England 57.6%.

If one examines the U.S. sample group relative to their combined level of knowledge against level of education and college major, the following results:

	Percent Scientifically Literatc
Less than High School	0%
High School graduate	5%
College Graduate	17%
Sci/Eng/Applied Sci	27%
Social Sciences	21%
Humanities/Fine Arts	15%
Business/Law	14%
Health Sciences	12%
Education	10%

Remember, fewer than 20% of our society have baccalaureate degrees.

We are a nation at risk! Our society, particularly our children, are becoming more and more scientifically illiterate. Why is this important to be discussed in this column? Because you as a physician have a potential impact on not only your patients, but also your community, our medical students, and particularly your area secondary schools. Recently, the National Research Society Sigma Xi, Youngstown State University Centennial Chapter, met at St. Elizabeth Hospital Medical Center and heard this presentation of findings by Jon D. Miller, Director, Public Opinion Laboratory, Northern Illinois University. Dr. Miller was here as part of the Cancer Symposium Program coordinated by Sudershan Garg, M.D. and his colleagues. The presentation/discussion was very dramatic in light of our personal biases.

Dr. Miller's research has now focused upon development of longitudinal data bases. Since 1987, a large sample of American high school sophomores has been studied and results indicate about 6.9 percent of students are classified as scientifically literate. Suppose this figure could be impacted upon and doubled or even tripled. Is 25% of our future population being scientifically literate sufficient to address the future needs of our society? Will we be capable of informed dialogue on matters of nuclear fusion, DNA research, and a host of other topics affecting our public decision-makers? Remember, in a system of government such as ours, public awareness is critical and sensitization of political leaders regarding matters of legislation and/or public policy is imperative. In America, an informed public is contingent upon understanding, knowledge, and dialogue. In this case, the knowledge of elementary science is particularly important to our general social well-being. For those persons in health care and medicine, in particular, we must have an informed and receptive public to address critical on-coming issues of the nineties and beyond. We must also have an informed base of future pre-medical students upon which to build a strong foundation for clinical problem solving and quality patient-care. Any help you could provide is not only needed, but essential.

Note: This information was excerpted from the presentation. Dr. Miller will present the data, stressing in detail the findings, causes, and implications in an upcoming Spring issue of Scientific American.

From the Bulletin

Robert R. Fisher, M.D.

Fifty Years Ago - December 1939

Editor H.E. Patrick wrote an article which should be read by all members today: "The future of medical practice is in the hands of the medical profession. Your responsiveness to, and handling of the changing conditions will determine whether medicine is to be a leading and constructive force in a changing society. You cannot ignore the situation. If you don't make it right, someone else will. So get out to the meetings, get on committees, acquaint yourself with the problems to be solved, and give of your time and thought. You are the best educated of any group in the community of which you are a part. Why not put that education to work for yourself and the community?"

Forty Years Ago - December 1949

The Sixth District Councilor Meeting was held in the Hotel Pick-Ohio on November 30th. A group of experts from the Lahey Clinic came and gave talks on arthritis, digestive disease and pulmonary disease. It was an all day affair with a dinner and lectures scheduled into 8:30 in the evening.

It was in this issue that the full significance of the anti-trust action of the Department of Justice was being felt. Twenty-two State and County Medical Societies, including the A.M.A. itself, were being investigated, and accused of restraint of trade. The board room of the A.M.A. was broken into during the night and records were thoroughly searched, but no one was ever arrested. (The first Watergate?) The A.M.A. called it "terrorism". It was the beginning of a ten year struggle with the Department of Justice.

ThirtyYears Ago - December 1959

Outgoing President Neidus expressed his appreciation for our Executive Secretary, Howard Rempes. He also made special mention of the assistance of Drs. Schreiber, Kiskaddon, McGregor, Randall and Shensa during the year.

All through this year's issues of the "Bulletin" there appear little whimsical, and sometimes philosophical comments under the pen-name of "Uncle Dudley" and also "Cynical Sam". Any old-timers out there who can remember who was behind these pen-names?

Twenty Years Ago - December 1969

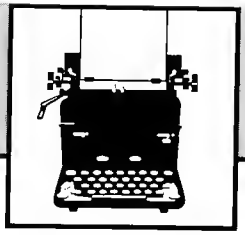
Outgoing President J.W. Tandatnik took a last lick at Socialized Medicine. "Humans still need freedom, incentives and free competition in order to produce excellent work". Outgoing editor D.J. Dallis was cheered by the moon walk, but discouraged by attendance at Society Meetings. President-Elect was J.F. Stotler, and the incoming secretary was Henry Holden.

Ten Years Ago - December 1979

Richard D. Murray, M.D. received the second annual "Doctor of the Year" award. Dr. Murray was cited for his outstanding contributions to the community, too numerous to mention here. He was called "One of Youngstown's most colorful physicians." Honored with pins for fifty years of medical practice were: Brack M. Bowman, William D. McElroy, John Noll and L.H. Moyer.

Dr. J. Paul Harvey died November 21, at the age of 87. A past-president of the MCMS in 1933, he was the author of a monthly newsletter, which later became the "Bulletin". He was founding member of the Ohio Chapter of the American College of Physicians.

New Members that month were: Active: A. Gary Bitonte, M.D., Eledath U. Krishnan, M.B.B.S., Karipineni R. Prasad, M.B.B.S. Associate: Alejandro A. Franko, M.D. and Gurbilash Nagpaul, M.B.B.S.



To The Editor

Dear Dr. Gordon:

Your editorial "Peer And The Elderly Physician," which appears in the November issue of the *Bulletin*, addresses some important issues but seems wide of the mark at some points. What kaiser Wilhelm did was to establish an arbitrary age for the payment of retirement benefits. This was appropriate for administrative purposes, but it's quite different from saying that all people become "elderly" at the same rate. Obviously, some begin to fail before their 65th birthdays, while others remain physically vigorous and mentally active long after passing that milestone. The number 65 does not appear in any dictionary definition of the word "elderly" that I can find.

Some doctors, especially those for whom practice is more of a burden than a pleasure, retire from practice in their late 50s or early 60s. Some continue practice until either they or their peers realize that it is time for them to quit. A few continue seeing patients long after their mental skills have started to deteriorate. Ideally, hospital privileges and medical licensure should continue as long as the doctor's patients are being well served and should then be withdrawn. In the real world this is often difficult to accomplish; it's tough to lower the boom on Good Old Joe, and if you do his friends will rally to his cause with vehemence. Frequently the evidence for failing performance is vague or subject to varying interpretation. Arbitrary rules that one stops doing surgery or delivering babies at a certain age are unfair to practitioners whose skills remain sharp, but at times there may be no workable alternative.

In family practice we must take a recertification examination every six years to remain board certified, but failing the exam would not keep us from continuing in practice. There is some theoretical justification for a state examination to measure one's ability to keep practicing after a certain age, but it would be essential to ensure that the test measures what it's supposed to measure - and that won't be easy!

It's important to note that the wisdom which may come with gray hair can have important benefits in patient care. Mature physicians may get to the root of problems more efficiently and with fewer lab tests than their younger peers. Hard experience has taught them to recognize and deal with human imperfections, including misunderstandings and socalled "compliance" problems. Having seen people age and die, and having experienced a few aches and pains themselves, they may be more tolerant of the problems of older patients, a group which, as your Editorial notes, is growing rapidly.

Senior physicians are obliged to keep up with whatever part of expanding medical knowledge is relevant to the needs of their patients, of course, but this is not the same as being expected to "know everything about everything." They must recognize their professional limits, but within these boundaries there are plenty of things for them to do to remain useful as physicians.

Sincerely,
Robert D. Gillette, M.D.

Peer Review and the Elderly Physician
A Different Opinion

Two years ago, I wrote an editorial emphasizing that "we" physicians need to maintain a unified identity as the head of a health care team whose primary goal is the well-being of its patients. On the other hand, "they" are those whose primary focus is cost-containment, profit and marketing - sometimes disguised today as Quality Assurance and Peer Review. Policies that would divide, and thus weaken, our profession are to "their" benefit. The divisive philosophy of discrimination expressed in November's Bulletin, directed against a segment of our physician population based solely on their age, illustrates that it is sometimes hard to distinguish between "we" and "they".

Designating the age of 65 as being elderly may have been appropriate 100 years ago, but with today's average life expectancy approaching the 8th decade, the designation is inappropriate. In the Mahoning County Medical Society, 45 of 115 members, and in OSMA 1252 of 3341 members over the age of 65 are in active practice. Most of them, like their younger peers, do an excellent job of caring for their patients. What gives peer review groups the right to decide that those who studied medicine 30 or 40 years ago have "fallen behind the times" and should be looked at more closely? Our State Medical Board recognized the need for continuing education to be a lifelong process, and made CME a requirement for relicensure. A number of the specialty boards require periodic recertification. There is no need to single out a specific age group for scrutiny. The fact that a physician does not meet continuing education or recertification requirements is just as important at 35 years of age as at 70 years. My personal experience is that the older physicians are usually the best-represented group in attendance at our educational programs.

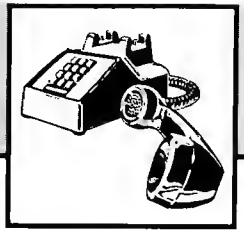
The belief that the older physicians "fail to have the knowledge to manage the whole case as a unit" is the opposite to what I believe is one of the older physician's greatest attributes. Many of them take care of elderly patients. They, and the families of their patients, have aged together. They are the ones best qualified to

coordinate the various studies and subspecialist recommendations. They have the empathy and the experience to be aware of the imapct of the illness on their patient and their patient's family. However, this is an area where the older physician often comes into conflict with the "one-size-fits-all" mentality of DRG's, Standards-of-Care and the Average-Length-of-Stay that Peer Review and Quality Assurance Committees use as their Bible. Unless we are careful, it is in the functioning of these committees that "we" might become "they".

The statement that "hospitals will be forced to take a greater look at all physicians...especially the elderly physicians because of inherent liabilities", is not necessarily true. There is no differential malpractice insurance rate imposed due to the age of a physician. As careful as insurance companies are to assess malpractice risk, I'm sure that they would have discovered this "inherent liability" by now if it existed. In conversation with a representative of one of the malpractice carriers recently, I was told that the good rapport and caring attitude that older physicians have for their patients probably makes them less of a liability risk.

Whatever the age of the physician, quality of care is something about which we must all be concerned. What is most important is that "we" have to remain in control of the process, and apply it equally and justly to all members of our profession. Nurse reviewers and physicians who haven't seen a real patient in 20 years have no right judging our professional quality. They can only do so if we relinquish that right to them. Allowing them to subject one segment of our profession to descriminative scrutiny is a step in the wrong direction. In those upcoming discussions at OSMA and AMA, the physicians involved in the legislative portion of peer review will have to be careful that they don't create a "bed of thorns" for elderly physicians in which they themselves may someday have to lie.

John R. LaManna Jr., M.D.



Classified Advertising

MEDICAL TRANSCRIPTION
& WORD PROCESSING SERVICE
Pick-up & Delivery - 482-5474
Prompt...Documented...Quality
S&C Enterprises, 87 South Shore Dr.,
Youngstown, Ohio 44512

FOR SALE
Recently reconditioned IBM typewriter
Model D - ($100.00)
Burrough Electric Calculator with tape
Model J 1000 - ($50.00)
Call 782-2642 before 6:00 p.m.

POSITION AVAILABLE
Part-time Secretary wanted for large Pathology Group.
20 hr. per week - salary negotiable.
P.O. Box 659, Youngstown, Ohio 44501

LIBERTY OFFICE SPACE
3132 Belmont Avenue - few minutes driving time to North Side unit, WRCS. 1200 square feet - ample parking. Available March 1990. (216) 759-0644.

OFFICE SPACE AVAILABLE
Medical or Dental office space available for rent. 624 Youngstown-Poland Rd., Struthers, OH. Call: (216) 755-1495.

OFFICE SPACE AVAILABLE
Ideal Liberty location, new building, abundant parking, immediate occupancy. Can take full advantage of office facility, computer, EKG, Full testing. Dr. Sanford Gaylord (216) 759-0885.

2.78 ACRES SUGARBUSH TRAIL
Located on quiet cul-de-sac. Wooded lot. Canfield Twp. Call Beth Bacani for details. Northern Hills Real Estate, 759-2517 or 759-0222.

FOR LEASE
Boardman Physician's Office (1400 Square Feet).
4410 Market Street Available July 1, 1990.
Contact: Dr. Martin Raupple, 788-6548 or 533-3185.

OFFICE SPACE
Prime Office Space on Route 224. Over 2100 square feet, will divide. Call 758-9365, 9 a.m. to 4 p.m. weekdays.

– Advertisers List –